WORDING NOTIFICATION OF APPROVED HEALTH CARE PLAN & AUTHORIZATIONS

LOCAL PRIMARY MEDICAL CARE:

- ✓ Local outpatient medical follow along care limited to (specific condition). Limited to (#) office visits without additional authorization

SPECIALTY:

- ✓ Outpatient (type) follow along care limited to (name of condition). Limited to (#) office visits without additional authorization.
- ✓ **If Orthopedic Add:** Includes x-rays up to $150.00 (reimbursed at Medicaid rate). Additional services must be prior authorized.

MULTIPLE SPECIALTY (CLINIC) NOTIFICATIONS:

- ✓ Outpatient specialty clinic follow along care for (name of condition). Limited to (#) office visits without additional authorization. (**If under contract, do not do the "limited to visits**")

HOSPITALIZATION (INCLUDING SURGERIES):

- ✓ Hospitalization for (name of procedure). Limited to (number) day(s). Additional services must be prior approved.

HOSPITALIZATIONS (WITHOUT SURGERY):

- ✓ Hospitalization limited to ($$) for treatment of (specific diagnosis). Additional services must be prior approved.

OUTPATIENT SURGERY:

- ✓ Outpatient surgery for (name of procedure); Limited to ($$). (Scheduled date, if know)

MEDICATIONS:

- ✓ Medications for (specific condition) as prescribed by the specialist. Limited to ($$). Additional services must be prior approved.

MILEAGE:

- ✓ Note: **No transportation authorizations are given to Medicaid recipients**. They are asked to call recipient assistance (1-888-240-6497) to prior approve travel.

- ✓ Mileage from (place of residence) to (place of treatment), (number of miles) per round trip at $.22 per mile. Not to exceed (number of trips) trips per year without additional authorization.

THERAPIES:

- ✓ (type of therapy) not to exceed (write out number) ½ hour sessions (or equivalent) for (purpose of treatment).

INTERPRETER SERVICES:

- ✓ Outpatient interpreter services related to (name of condition) as needed. Limited to (#) visits without additional authorization.

AUTHORIZATION FOR DIAGNOSTIC SERVICES:

- ✓ Outpatient one time diagnostic (specialty) evaluation, including labs and x-rays to rule out (suspected condition). Please schedule the appointment (if scheduled, give date). **See attached sheet (1-1-06 wording) for more examples**

HEMOPHILIA AND SICKLE CELL AUTHORIZATIONS:

- ✓ **HEMOPHILIA**

    1. Outpatient one time comprehensive hemophilia clinic visit to include labs and x-rays. To be funded by the Special Bequest Fund.

- ✓ **SICKLE CELL/FOR USE OVER 21 YEARS**

    2. Follow along care for sickle cell to include labs and x-rays. Total care limited to $7,000.00 per year.

DENTAL AND ORTHODONTIC CARE :

- ✓ **DENTAL** (ORAL SURGERY TO BE AUTHORIZED UNDER SPECIALTY WORDING)

  General Dental Care as needed.

ORTHODONTIC TREATMENT EVALUATION:

- ✓ One time orthodontic evaluation and treatment plan; to include x-rays, labs, study models, etc. Please schedule an appointment.

NEW TREATMENT ORTHODONTIC (AFTER PLAN):

- ✓ Orthodontic treatment as outlined in the report dated _____. Initial fee of $_____ and $_____ per month for (number of) months.

HEARING AID PURCHASE:

- ✓ One time purchase of hearing aid (s) including fitting and dispensing.

HEARING AID REPAIRS:

- ✓ Hearing aid repairs limited to $75.00 per repair per aid. Molds and batteries as needed.

TRANSFERRING OF SERVICES:

- ✓ Transferring services for (wording of original authorization) from (doctor/pharmacy/clinic, etc) to:
  ie: Transferring orthopedic care from Dr. Pence; including x-rays and labs to:
  ie: Transferring medication for seizures as prescribed from Dillons Pharmacy to:
  ie: Transferring braces from Capitol Orthopedic as prescribed to:
  ("Additional services must be prior approved" will need to be added at end of authorization)

LABS AND X-RAYS FOR KUMC:

- ✓ Authorization for x-rays related to (name of condition) as ordered by the specialist. All services over $150.00 (reimbursed at Medicaid rate) must be prior approved.◄
- ✓ X-rays for KUMC care to be authorized with KUMC Clinical Radiology.
- ✓ **Anytime a provider at KUMC is authorized, a separate authorization will need to be done to KUMC for lab and x-ray procedures.** (use same wording as above) ◄

WESLEY CLINIC:

- ✓ When authorizing the **Cerebral Palsy Clinic or Dr. Battiste**, a separate authorization will need to be done to Wesley Medical Center for labs and x-rays. See wording above for KUMC. Dr. Battiste does Echo, EKG and Doppler in her office; make sure to put the additional testing working on the authorization. (If x-rays are needed, will have to do with Wesley per Julie McCoy)

WORDING FOR OTHER VARIOUS AUTHORIZATIONS:

- ✓ **BRACES**
  - ❖ Authorization for purchase of braces (orthotics) as prescribed by (either "the specialist" or Doctor ordering braces). Limited to one pair. If additional braces are needed, call for prior authorization.
  - ❖ **ie: Authorization for purchase of braces as prescribed by Dr. Olney or.**
  - ❖ **ie: Authorization for purchase of braces as prescribed by the specialist.**

- ✓ **LABWORK**
  - ❖ Outpatient labwork related to (condition ie seizures) as prescribed by _____. All lab work over $150.00 (reimbursed at Medicaid rate) must be prior authorized.
  - ❖ ie: **Outpatient lab work related to seizures as prescribed by Dr. Shah.** All lab work over $150.00 (reimbursed at Medicaid rate) must be prior authorized.

- ✓ **ANESTHESIA** (to be used when surgery is authorized at KUMC).
  - ❖ Anesthesia for (name of procedures). Scheduled for/or done _____.
    ie: Anesthesia for palatoplasty. Scheduled for August 31, 1999.
    ie: Anesthesia for palatoplasty. Done on August 30, 1999.

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